Medicaid Maternity Town Hall Comments

Below is a summary of the wide variety of issues and opinions discussed at the town hall meetings held December 8, 2008 – January 29, 2009 in Tuscaloosa, Birmingham, Mobile/Spanish Fort, Montgomery and Huntsville.

Society

- Sicker patients
- Economy has changed
- Need to reach out using the internet with mySpace, etc. Look at what kids do.

Infant Mortality Data

- Providers have expressed concern over lack of consistent application of what is and is not a viable fetus. Dr. Williamson responded that we are using the same standard throughout the country, but application can vary from practitioner to practitioner.
- FIMR data will help analyze better (including providing better demographic mapping and other circumstances surrounding death)
- A concern was expressed that as a state we may be signing birth certificates for non-viable fetuses for many reasons: cultural, funerals, etc.

ADPH suggested interventions based on infant mortality data

- FIMR
- Expand prenatal care via SCHIP and in general
- Family Planning
- Interpregnancy care for a targeted group
- Smoking cessation

Education/Care Coordination

- Education: Most felt that individual instruction was more effective than group situations. Care coordinators asked for increased education (materials and classes) to be provided to recipients in the areas of breast feeding/birth control/effects of alcohol and need to avoid/taking folic acid/perinatal outcomes regarding maternal request for early delivery
- Home visits: Input varied. Some CC's want home visits (can't catch them all in the hospital and pt's may have info overload) and some do not (can't find at home, most visits are not successful, wrong contact information).
- Flexibility in Care Coordination: PC's want greater flexibility for CC's. Don't require 4 visits on every patient. Some patients may need just one visit. This would allow them to have more time for the patients that truly need more visits.
- Flexibility in Performance Improvement Projects (PIP): Allow PC's flexibility in designing PIP's. Let them use PIP's for issues that are significant in their areas. This could also identify some unique, thoughtful best practices.
- Department of Education: Need to meet with Education department to explore options. Can we build on a 90/10 match with Family planning to help? School based screenings occur like scoliosis, can they not include education about pregnancy planning, etc. Can ADPH reach out to the Department of Education for coordinated education to the public?
- Educational programs: DARE program re drugs., March of Dimes has a program with objectives. Smoking, pregnancy, causes of preterm deliveries.

- General public education: Need to educate general society about not delivering before 39 weeks electively. Public Service Announcements were suggested. Can ADPH help?
- Community Resource utilization: CC's need to fully use community resources for things like nutritional education: WIC can help, some churches help, some hospitals have initiatives in this area also.
- Consider home care monitoring vs. inpatient care for preterm delivery.
- Educational Materials: Request was made for Medicaid and ADPH to put together a package of educational materials for patients that provides basic information. Another in the audience noted that March of Dimes produces materials.

Substance Abuse and Access to Care

- Access: More providers and facilities needed. Patients are more likely to use services if they are immediately available. Methadone Clinics are hesitant to take on pregnant women.
- Coverage for brief intervention called SBRIT: Some patients will never go to a treatment center, but would see their doctor if they could provide intervention (please note that non-rehab MD's are limited in their treatment of addictions). Alethia House Resources: Chris Rotan with Alethia House volunteered to have meetings in Birmingham area and the rest of the state. Alethia House has doubled their inpatient beds through a grant.
- Education for Providers: Need to educate providers about services that are there and how to contact them.
- Key to getting patients into treatment: Care Coordinators: MD should call CC. Access is a problem in some areas but not in others. Where it is not an issue, the CC's are really being utilized to make the contacts.
- Mental Health: Not enough mental health resources.

Smoking

- Multi-layered approach was recommended: Groups want more public service announcements, increase tobacco tax.
- Smoking cessation medications need to be provided.
- Incentives to quit might help.
- The Alabama Quit Line was not seen as a valuable tool. It was difficult to get through to someone.

Inter pregnancy care for women with a previous adverse pregnancy outcome (fetal demise or VLBW infant)

- Proposal is being worked on.
- Linkage with Medical Home: look at a way to link inter-pregnancy care with pediatrician practices.

Physician Care/ Primary Care Prenatal Care

- Increased reimbursement is requested.
- Primary Care Prenatal Care: PC's could do this but the contractors felt there were enough dollars within the global to capture this venue.
- Physicians should be given some type of incentives to use a second tier of Nurse practitioners or midwives.

Eligibility

- Patient Related Delays: Some women see no value in prenatal care. Some women wait until gestational age is 20 weeks so U/S will show sex of infant.
- Barriers: Barriers with requirements for proof of citizenship and identity, getting birth certificates seems to be the main issue. In state and out of state birth certificates are an issue. Could this be discussed in national public health organizations?
- System Improvements: Application assisters may help.
- Eligibility System: performance is variable.
- In many areas establishing eligibility is not a problem with it being established in as little as one day. These areas say they have a lot of outreach from the PC's to the eligibility workers. There may be more co-location in those areas. A good relationship is seen as the key.
- In other areas, it is very inefficient and requires a full 45 days. In those areas, SOBRA workers are inefficient, hard to find, don't return phone calls. Workers need to be held more accountable.
- Need to develop a system for reporting complaints about eligibility workers. 1-800 number doesn't get a quick response nor does email.
- Input from town halls indicates improvement needs to come from ground up with the PC getting very local CC's and eligibility workers together and highlighting that the lives and health of women/children is at stake. Many of the issues are local and specific to certain people or offices.
- Presumptive eligibility: It takes as long to get presumptive eligibility as it does to get regular eligibility. Not a solution.
- Language and cultural barriers exist in some areas. CC's need to identify community resources, churches , etc. that will help.
- The eligibility workers need to push insurance coverage under COBRA to continue. Most opt to drop it.

Birth Control/Plan First/Family Planning

- Needs to be more readily available. One mechanism that expressed repeatedly was to stop requiring women to go to the health department. The most consistent recommendation was to allow the physicians' prescriptions to be filled at the pharmacy. It was suggested women could go to Walmart (or other companies that would match their price) and get their prescriptions for $4. On evaluation, Walmart does not have any OC's for $4 and only 2 on their $9 list.
- Hospitals do not accommodate tubals while patient is still in the hospital, results in many patients coming back pregnant.
- Can University pharmacies be dispensing pharmacies under 340 B pricing contracts? ADPH is to evaluate.
- Improved handoff process from MCP to Plan First has been discussed already.

Hospitals

- Hospital costs go up daily and have no increase in years. Additional money should not come from other areas of the program.
- More money needs to be put into the program or hospitals/primary contractors will not participate.
- In or Out of the MCP: Some areas expressed a strong desire to have hospitals out of the contract, while others expressed a strong desire to keep hospitals in the contract.
- Several have expressed the program may be jeopardized due to hospitals need for more money.

Districts

- Changing the size or shape of the districts: Most input was to keep districts the same because of the sense of community/volunteerism on working through problems. Larger districts were felt to be hard to administer. Some felt larger districts would help promote better communication/coordination. If redistricting would help improve access or save money, then it would be worthwhile, but not if redistricting could not accomplish either.
- Some suggested the PC's have to offer a 50 mile/50 min network for each patient, but patients can elect to go outside their district if the patient chooses to do so.

Lack of Maternal Weight Gain

- Recipient should be referred for nutritional counseling. Many felt the care coordinators could do enough.
- Some CC's give gift certificates.
- CC's need to do a better job of identifying community resources.

Maternal / Physician request early induction or C-section

- ACOG criteria should be utilized and use physician report cards
- Some have suggested this is not a Medicaid issue
- Increase education to mom's about the impact.

Centering Pregnancy

- Augmented prenatal care in the UAB system did not make a difference in a 2001 study, but this was compared against usual UAB care.
- March of Dimes had funded a grant for EAMC
- Most places are not doing this.

Access

- Difficulty finding physicians in rural areas is a significant problem
- This also makes transportation a real issue and results in fewer prenatal visits.
- NET: non-emergency transportation is being utilized by many, but Medicaid will explore how the system can be streamlined.

Incentives for patients

- Can an incentive be provided for patients who: breast feed, not smoking, etc. We need to reward good behavior. Currently there are rewards for bad behavior (SSI checks for premature infants. We reward with WIC and formula for premature infants, but nothing for the woman who breast feeds).

17 Alpha Progesterone

- Work on reimbursement issues
- Provide a list of compounding pharmacies.

Communication

- Sharepoint/Blog site/website for sharing ideas, information, posing a question from PC's and CC's. Also a way to share strategies that have been found helpful.

Transportation

- We need more transportation resources. Some groups are lobbying for better statewide public transportation.
- NET is being utilized. We are looking at streamlining this process.
- Vouchers takes too long. Takes 4-6 weeks to get transportation. Pt's don't get a response and call for ambulance.

Should MFM consultation be required in certain instances?

- Do not require referral for MFM: OB/GYN's can handle 90% of cases. Quality and timeliness of consults from UAB are not consistently good.

Tracking

- Build on electronic health record as a methodology for tracking those that are high risk.

Oral Health

- Poor oral health is associated with worse birth outcomes. Providing oral health care is not associated with improved outcomes.

Monitoring

- Can we provide in home monitoring vs. inpatient care for preterm labor?

Patient Accountability

- More is needed.